

# Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935  
Madison, WI 53708-8935  
FAX #: (608) 261-7083  
Phone #: (608) 266-2112

1400 E. Washington Avenue  
Madison, WI 53703  
E-Mail: [web@drl.state.wi.us](mailto:web@drl.state.wi.us)  
Website: <http://www.drl.state.wi.us>

## DIVISION OF PROFESSIONAL CREDENTIAL PROCESSING BUREAU OF HEALTH PROFESSIONS

### IMPORTANT INFORMATION

Applicants, recruiters and institutions and others involved in the placement of individuals who seek to be credentialed in the state of Wisconsin should understand that the credentialing process **may take anywhere from 30 to 60 days**, and that credentialing is not guaranteed to any applicant. Some factors that determine the length of time it may take to process an application depends on the length of time the applicant has been in practice, the total number of jurisdictions the applicant has been credentialed in and the length of time it takes for supporting documents to be received in the board office and reviewed.

The application consists of an all-inclusive packet with instructions and information on all applicable requirements. We attempt to process applications in a timely fashion. We cannot issue a credential until all the required documents have been received and reviewed in the board office. It is the Department's legislative mandate to provide consumer protection for Wisconsin residents.

The Bureau and the Board have been prevailed upon to waive requirements to expedite the process, only to discover legitimate grounds to deny a credential. This can present a serious problem for the applicant, recruiter or institutions if the applicant has relocated, purchased property, or made other commitments prior to the issuance of a Wisconsin credential. **We urge you not to make these moves until you know that your credential has been issued.**

Please "plan ahead" as we cannot speed up the credentialing process nor waive supporting documents even in emergency situations.

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## DIETITIANS AFFILIATED CREDENTIALING BOARD

### APPLICATION FOR CERTIFICATION TO PRACTICE AS A DIETITIAN

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

**PLEASE TYPE OR PRINT IN INK** ☐ Your name and address are available to the public.  
☐ Check box if you wish your name & address withheld from lists of 10 or more credential holders (sec. 440.14, Stats.).

Last Name	First Name	MI	Former / Maiden Name(s)
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Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth ____ month ____ day ____ year	Daytime Telephone Number (____) _____ - _____
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Ethnic/gender status information is optional. Sex: ☐ M ☐ F Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

Have you ever held a license/credential in the state of Wisconsin? \_\_\_\_ Yes \_\_\_\_ No (please indicate)  
If yes, provide your Wisconsin license/credential number. \_\_\_\_\_

School Name: \_\_\_\_\_  
(Dietitian degree for credentialing)

School Address: \_\_\_\_\_  
(City) (State)

Date Diploma Granted: \_\_\_\_\_  
month/day/year

Degree: (Circle one) BS MS Dr Other Specialty: \_\_\_\_\_

<b>BOARD OFFICE USE ONLY</b> Temporary Permit Requested: ____ Yes ____ No
--

**APPLICATION FEES** Please check applicable blank: (Make check payable to Department of Regulation and Licensing and attach to application).

\_\_\_\_ **EXAM CANDIDATE:**

\$ 53.00 Total Fee Attached

\_\_\_\_ **TEMPORARY CERTIFICATE ISSUED PRIOR TO PERMANENT CERTIFICATION** (Only for candidates applying by examination)

\$ 10.00 Is required in addition to the above fee (non-refundable)

\_\_\_\_ **RECIPROCAL CANDIDATES:** (Candidates who hold or held a credential in another state and have taken the ADA\* examination)

\$ 56.00 Reciprocal Fee

\_\_\_\_ **RECIPROCAL CANDIDATES:** (Candidates who have taken a state board examination other than ADA\* examination)

\$ 56.00 Reciprocal Fee

\*American Dietetic Association

#2113 (Rev. 8/03)  
Ch. 457, Stats.

### For Receiving Use Only

# Wisconsin Department of Regulation & Licensing

**PLEASE REVIEW SECTIONS 1-4. CHECK THE SECTION UNDER WHICH YOU ARE SEEKING A CREDENTIAL.** Under each section is a list of documents required for the credential. **Your application will not be considered complete until all of these documents have been received in the board office.** For your convenience we have added a check list.

## SECTION 1

### ☐ **PERMANENT CERTIFICATION BY EXAMINATION.**

- ☐ Completed application (Form #2113)
- ☐ Fee(s) attached to this application (Form #2113)
- ☐ Copy of professional diploma and translation if necessary.
- ☐ Certificate of Professional Education (Form #2111)
- ☐ Proof of passage of the American Dietetic Association (ADA) examination, or "Verification of Registration" (Form #2115)
- ☐ Practice of Dietetics (Form #2128)
- ☐ Social Security Number (Page 6 of 6 Form #2113)

## SECTION 2

### ☐ **PERMANENT CERTIFICATION FOR RECIPROCAL CANDIDATES (who held or holds a credential in another state and has taken the American Dietetic Association (ADA) Examination).**

- ☐ Completed application (Form #2113)
- ☐ Fee(s) attached to this application (Form #2113)
- ☐ Copy of professional diploma and translation if necessary.
- ☐ Certificate of Professional Education (Form #2111)
- ☐ Proof of passage of the American Dietetic Association (ADA) examination, or "Verification of Registration" (Form #2115)
- ☐ Practice of Dietetics (Form #2128)
- ☐ Social Security Number (Page 6 of 6 Form #2113)
- ☐ A letter of verification of licensure or certification from another state or U.S. Territory submitted directly from that state board.

## SECTION 3

### ☐ **PERMANENT CERTIFICATION FOR RECIPROCAL CANDIDATES (who have taken a state board examination other than the American Dietetic Association (ADA)).**

- ☐ Completed application (Form #2113)
- ☐ Fee(s) attached to this application (Form #2113)
- ☐ A letter of verification of licensure or certification from another state or U.S. Territory submitted directly from that state board.
- ☐ A copy of the state's rules and regulations pertaining to the practice of dietetics.
- ☐ Social Security Number (Page 6 of 6 Form #2113)
- ☐ Copy of professional diploma and translation if necessary.
- ☐ Certificate of Professional Education (Form #2111)
- ☐ Practice of Dietetics (Form #2128)

## SECTION 4

### ☐ **TEMPORARY CERTIFICATE issued prior to permanent certification. (Only for candidates applying by examination.)**

- ☐ Completed application (Form #2113)
- ☐ \$63.00 fee attached to this application (Form #2113)
- ☐ Copy of professional diploma and translation if necessary.
- ☐ Certificate of Professional Education (Form #2111)
- ☐ Practice of Dietetics (Form #2128)
- ☐ Request for a Temporary Dietitian Certificate (Form #2112)
- ☐ Social Security Number (Page 6 of 6 Form #2113)

# Wisconsin Department of Regulation & Licensing

**IS NAME ON ALL CREDENTIALS THE SAME? IF NOT, SUBMIT A CERTIFIED COPY OF MARRIAGE CERTIFICATE, DIVORCE DECREE, ETC.**

**PLEASE CHECK ONE FOR TEMPORARY CERTIFICATE:**

- \_\_\_\_\_ I plan to take the next ADA Registration Examination.  
\_\_\_\_\_ I have taken and am awaiting the results of the ADA Registration Examination.

**I AM CREDENTIALLED IN THE FOLLOWING STATES (UNLIMITED):**

**YOU ARE REQUIRED TO HAVE EACH STATE BOARD IN WHICH YOU HAVE EVER BEEN CREDENTIALLED SUBMIT LETTERS OF VERIFICATION TO THE WISCONSIN DIETITIANS AFFILIATED CREDENTIALING BOARD. THE LETTERS MUST INDICATE YOUR DATE OF BIRTH, CREDENTIAL NUMBER, DATE OF ISSUANCE, AND A STATEMENT REGARDING DISCIPLINARY ACTIONS. THESE LETTERS WILL BE REQUIRED IN ORDER TO COMPLETE YOUR APPLICATION FOR CERTIFICATION.**

**ANSWER THE FOLLOWING QUESTIONS:** (Attach additional sheets if necessary)

	<u>YES</u>	<u>NO</u>
1. Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	<input type="checkbox"/>	<input type="checkbox"/>
3. Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation, revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	<input type="checkbox"/>	<input type="checkbox"/>
4. Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any felony or misdemeanor charges pending against you? If yes, attach a sheet providing details about the pending charge, copy of the court documents and status of the charge. (Please do not give details on minor traffic charges, but do include information relating to <u>Driving While Intoxicated</u> (DWI) charges.)	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been convicted of a misdemeanor or a felony? If yes, attach a sheet providing details about the crime, including date of conviction, penalty and a copy of the court documents. (Please do not give details on minor traffic convictions, but do include information relating to <u>Driving While Intoxicated</u> (DWI) charges.)	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.	<input type="checkbox"/>	<input type="checkbox"/>
8. Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.	<input type="checkbox"/>	<input type="checkbox"/>
9. Have your privileges ever been limited or removed? If yes, give details on an attached sheet.	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s).	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under.	<input type="checkbox"/>	<input type="checkbox"/>

# Wisconsin Department of Regulation & Licensing

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice as a dietitian" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned dietetic judgments and to learn and keep abreast of dietetic developments; and
2. The ability to communicate those judgments and dietetic information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform dietetic tasks such as examination and treatment procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years**.

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

- |  | <u>YES</u>               | <u>NO</u>                |
|--|--------------------------|--------------------------|
| 12. Do you have a medical condition which in any way impairs or limits your ability to practice as a dietitian with reasonable skill and safety? If yes, please explain.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Does your use of chemical substance(s) in any way impair or limit your ability to practice as a dietitian with reasonable skill and safety? If yes, please explain.  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are you currently engaged in the illegal use of controlled dangerous substances?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |

# Wisconsin Department of Regulation & Licensing

## AFFIDAVIT OF APPLICANT (Sign and date in the presence of a notary)

I state that I am the person referred to on this application and that all the answers set forth are each and all strictly true in every respect. I understand that false or forged statements made in connection with this application may be grounds for revocation of my credential. I also understand that if I am issued a credential, failure to comply with the laws or rules of either the Dietitians Affiliated Credentialing Board or the Wisconsin Department of Regulation and Licensing will be cause for disciplinary action.

\_\_\_\_\_  
Signature of Applicant

State of \_\_\_\_\_ County of \_\_\_\_\_

Subscribed and sworn to before this \_\_\_\_\_ day of

\_\_\_\_\_, 20\_\_\_\_, by \_\_\_\_\_  
(Applicant name)

\_\_\_\_\_  
Signature of Notary Public

**S E A L**

\_\_\_\_\_  
Date Commission Expires

# Wisconsin Department of Regulation & Licensing

**SOCIAL SECURITY NUMBER.** Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.<sup>1</sup> A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

\_\_\_\_\_  
First Name Middle Initial Last Name

\_\_\_\_\_  
Profession

Date of Birth    \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_  
                                 month                   day                   year

-  -

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program,<sup>2</sup> to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,<sup>3</sup> and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.<sup>4</sup>

<sup>1</sup> Section 440.03 (11m), Wis. Stats.

<sup>2</sup> Sections 49.22, and 440.13, Wis. Stats.

<sup>3</sup> Section 440.12, Wis. Stats.

<sup>4</sup> Health Insurance Portability and Accountability Act (HIPAA) of 1996

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## DIETITIANS AFFILIATED CREDENTIALING BOARD REQUEST FOR VERIFICATION OF REGISTRATION

### DIETITIANS

**APPLICANT MUST COMPLETE THIS FORM AND FORWARD TO THE  
COMMISSION ON DIETETIC REGISTRATION AT THIS ADDRESS:**

**COMMISSION ON DIETETIC REGISTRATION  
216 WEST JACKSON BLVD SUITE 800  
CHICAGO IL 60606-6995**



\_\_\_\_\_  
APPLICANT'S SIGNATURE

\_\_\_\_\_  
DATE

### PLEASE PRINT

\_\_\_\_\_  
NAME (Last, First, Middle)

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY, STATE AND ZIP

\_\_\_\_\_  
NAME ON REGISTRATION EXAMINATION RECORDS IF DIFFERENT FROM ABOVE

\_\_\_\_\_  
ADA REGISTRATION NUMBER

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### COMMISSION ON DIETETIC REGISTRATION

The **State of Wisconsin** requests a verification of registration concerning the above individual. **Please mail the response to the following address:**

Department of Regulation and Licensing  
Dietitians Affiliated Credentialing Board  
1400 East Washington Avenue  
P.O. Box 8935  
Madison, WI 53708-8935



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## DIETITIANS AFFILIATED CREDENTIALING BOARD

### DIETITIANS CERTIFICATE OF PROFESSIONAL EDUCATION

THIS FORM MUST BE COMPLETED BY YOUR PROFESSIONAL SCHOOL  
AND RETURNED TO THE DIETITIANS AFFILIATED CREDENTIALING BOARD

#### APPLICANT - Please complete this section.

NAME (First, Middle, Maiden, Last)

Social Security Number\*

\_\_\_\_ - \_\_\_\_ - \_\_\_\_

ADDRESS (City, State, Zip)

Date of Graduation

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

#### CERTIFYING SCHOOL - Please complete this section.

NAME OF INSTITUTION

LOCATION OF INSTITUTION

DEGREE AWARDED

MAJOR

DATE OF DEGREE

\_\_\_\_\_  
Signature of Dean or Department Head

\_\_\_\_\_  
Date

**SCHOOL SEAL**

\* For use in the school locating your records.

#2111 (Rev. 03/03)

Ch. 448, Stats.

Committed to Equal Opportunity in Employment and Licensing

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## DIETITIANS AFFILIATED CREDENTIALING BOARD

### DIETETICS PRACTICUM EXPERIENCE

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_  
(Please Print)

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

Enter the number of hours you have completed as practicum experience in the three areas that are listed below. Your total must be at least 900 hours. **After you have completed this portion, you must send the form to the person who supervised you or is authorized to attest to your completion of these hours.**

### HOURS

#### \_\_\_\_\_ **CLINICAL DIETETICS:** (300 hours minimum needed)

Experience to include: Patient screening, assessment, care planning, implementation and monitoring of care plans, documentation of services provided, referral to other resources and assurance of inclusion of professional standards in delivery of such services. Examples of where experience may be obtained: hospitals, clinics, home health care agency or nursing home.

#### \_\_\_\_\_ **FOOD SERVICE ADMINISTRATION:** (120 hours minimum needed)

Experience to include: food planning, production, distribution, safety, sanitation, and employee supervision of food service operation. Examples of where experience may be obtained: hospitals, schools, prisons, nursing homes or contract food provider.

#### \_\_\_\_\_ **COMMUNITY NUTRITION:** (120 hours minimum needed)

Experience to include: identification of sources of data to assess health and nutrition status of population groups, assess learner needs and abilities of targeted population, plan programs to meet needs of target population, monitor/evaluate progress of nutrition programs and assure inclusion of professional standards in the delivery of such services. Examples of where experience may be obtained: WIC programs, commodity food programs, congregate meal programs, or allied health programs.

#### \_\_\_\_\_ **TOTAL HOURS** (Must equal 900 hours)

# Wisconsin Department of Regulation & Licensing

## AFFIDAVIT

I attest to the fact that \_\_\_\_\_ completed at least 900 hours of Practicum  
(name of applicant)

Experience for Certified Dietitians under the supervision of \_\_\_\_\_ who was a:

(Please check one)

☐

Certified Dietitian

☐

Registered Dietitian

☐

An individual who has a doctoral degree in human nutrition, nutrition education, food and nutrition, dietetics, or food systems management

\_\_\_\_\_  
Signature of Supervisor or Authorized Agent

(\_\_\_\_\_) \_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

**RETURN THIS FORM TO:**

**DEPARTMENT OF REGULATION & LICENSING**  
**DIETITIANS AFFILIATED CREDENTIALING BOARD**  
PO BOX 8935  
MADISON WI 53708

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## DIETITIANS AFFILIATED CREDENTIALING BOARD

### REQUEST FOR A TEMPORARY DIETITIAN CERTIFICATE

NAME OF APPLICANT: (Please print) \_\_\_\_\_

---

I hereby make application for a temporary certificate to practice as a dietitian at \_\_\_\_\_,  
(Facility)

in \_\_\_\_\_, Wisconsin, beginning \_\_\_\_\_, 20 \_\_\_\_\_.  
(City) (Month/Day)

I understand that this temporary certificate entitles me to practice dietetics for a period of 90 days.

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## AFFIDAVIT OF INDIVIDUAL SUPERVISING APPLICANT

I request that a temporary certificate to practice as a dietitian be issued to the above named individual for practice at \_\_\_\_\_, in \_\_\_\_\_, Wisconsin. I certify  
(Facility) (City)

that I hold a Wisconsin certificate to practice as a dietitian, that I shall be responsible for his/her direct supervision and training. I understand that the temporary certificate will be revoked by the board upon receipt of my signed statement that I wish to cease supervising this individual.

\_\_\_\_\_  
Facility

\_\_\_\_\_  
Signature and Title of Supervisor

\_\_\_\_\_  
Facility Street Address

\_\_\_\_\_  
Print Name and Wisc. Certificate Number

\_\_\_\_\_  
City and State

#2112 (Rev. 8/03)  
Ch. 448, Stats.

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## CONVICTIONS AND PENDING CHARGES

If you have been convicted of a crime or have criminal charges pending against you, complete this form and return it with your application. Include a \$6.00 Crime Information Bureau report fee in addition to your original application fees.

The Fair Employment Act (sections 111.31-111.395, Wis. Stats.) prohibits employment discrimination on the basis of conviction record or arrest record unless the circumstances of the conviction or arrest substantially relate to the circumstances of the particular job or licensed activity. The information requested on this form will be used to determine whether your application should be granted, approved with limitations, or denied. The information you provide on this form may be verified against criminal information records. Omission of information on this form will be considered a false statement on an application.

Profession you are applying for: \_\_\_\_\_

Last Name	First Name	MI	Former / Maiden Name(s)
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Your Street Address (number, street, city, state, zip) \_\_\_\_\_

Mail To Address (if different) \_\_\_\_\_

Date of Birth	Social Security Number
_____ month      day      year	_____ Information helps us identify your record, but is voluntary. It is not available to the public.

Ethnic/gender information is required to check criminal information records. Sex: ☐ M ☐ F Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

1. List all other names used: \_\_\_\_\_
2. List all felonies, misdemeanors, and other violations of state or federal law of which you have ever been convicted, in this state or any other, whether the conviction resulted from a plea of no contest or a guilty plea or verdict. For each, list the date and location of the conviction. Please include all convictions that involved alcohol or other drug use, including convictions for operating while intoxicated. Do not include municipal ordinance violations or other traffic offenses.

**It is your responsibility to submit certified copies of the police report or criminal complaint, judgment of conviction and sentencing, and verification of your compliance with all terms of each sentence, including chemical dependency assessments if ordered by the court. If the conviction is old and records have been destroyed, you must submit a written description of each offense, along with an explanation of the penalties imposed and verification that you completed all requirements.**

OFFENSE

DATE

CITY/STATE

Attach additional sheet(s) if necessary.

# Wisconsin Department of Regulation & Licensing

3. Have you ever been sentenced by a court to participate in an alcohol or other drug assessment, treatment or counseling program? YES NO MO/YR COMPLETED  
☐ ☐ \_\_\_\_\_  
Did you successfully complete the program? ☐ ☐ \_\_\_\_\_  
Please attach the certificate of completion/discharge summary.

(Check all that apply)

4. Have you ever been sentenced to: YES NO MO/YR COMPLETED  
☐ Probation ☐ ☐ \_\_\_\_\_  
☐ Parole ☐ ☐ \_\_\_\_\_  
☐ Ordered to pay restitution ☐ ☐ \_\_\_\_\_  
Did you successfully complete one of the above as ordered by the court? ☐ ☐ \_\_\_\_\_

If you are currently on probation or parole, you must request your probation/parole officer to send a letter describing your current probation/parole requirements and your compliance with supervision.

5. List all felonies, misdemeanors, or other violations of state or federal law for which you have been arrested and which are pending. Submit a copy of the police report/criminal complaint for each of the following pending charges.

<u>PENDING CHARGE</u>	<u>DATE OF ARREST</u>	<u>LOCATION OF ARREST (city/state)</u>
-----------------------	-----------------------	--


Comments you wish to make regarding your convictions or pending charges. Attach another sheet if necessary.


## AFFIDAVIT OF APPLICANT

I state that I am the person referred to in this document and that all the information which I provided above is true in every respect. I understand that false or forged statements made in this document in connection with my application for a credential, or failing to provide relevant information, may be grounds for denial of the application, revocation of the credential granted to me, or criminal prosecution. This document must be signed before a notary public.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

Signature of Notary Public \_\_\_\_\_ Date \_\_\_\_\_

My commission (is permanent) \_\_\_\_\_ expires \_\_\_\_\_.

**SEAL**

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**Mail To:** P.O. Box 8935  
Madison, WI 53708-8935

**FAX #:** (608) 261-7083  
**Phone #:** (608) 266-2112

1400 E. Washington Avenue  
Madison, WI 53703  
**E-Mail:** [web@drl.state.wi.us](mailto:web@drl.state.wi.us)  
**Website:** <http://www.drl.state.wi.us>

## NOTICES

### **TIME FOR REVIEW AND DETERMINATION OF CREDENTIAL APPLICATIONS**

Generally, a credentialing authority is required to make a determination on an original application for a credential within 60 business days after a completed application is received.<sup>a</sup> An application is completed when all materials necessary to make a determination on the application and all materials requested by the licensing authority have been received.

### **PROCEDURES ON APPLICATION DENIAL**

An applicant who receives a notice of denial may request a hearing to challenge the denial by filing a request with the appropriate board or the department within 45 days after the mailing of the notice of denial. The request must contain the applicant's name and address, the type of license sought, the reasons why a hearing is requested and a description of the mistake the applicant believes was made, if the applicant claims that the denial was based on a mistake of fact or law. Hearing procedures are specified in ch. RL 1 of the Wisconsin Administrative Code. A copy of ch. RL 1 is available at most public libraries, on the Internet through the index at <http://www.legis.state.wi.us/rsb/code/rl/rl.html> and may also be obtained from the department.

### **MAILING ADDRESS AND CHANGE OF ADDRESS**

Credential holders may use a business address as a mailing address for department mail. A change of address must be reported to the department within 30 days.

### **PERSONALLY IDENTIFIABLE INFORMATION: USE AND AVAILABILITY**

Information collected on an application form is required and will be used to determine eligibility for a credential or examination. It is not likely that the department will use information collected by these forms for other purposes.

Credentialing is a public process with a goal of identifying those competent to protect the public. The name, city, and status of credential holders are accessible at the Department's website at <http://www.drl.state.wi.us/> under "Credential Holder Query." Information collected on application and examination forms is available for inspection to the public under Wisconsin laws governing public records.

### **AMERICANS WITH DISABILITIES ACT**

The Department complies with the Americans With Disabilities Act of 1990. The Department will make reasonable modifications to policies, practices and procedures when modifications are necessary to avoid discrimination on the basis of disability and will make reasonable accommodations necessary to provide a qualified individual with a disability with equal access to department programs.

**Communications and examinations:** Individuals who need auxiliary aids for effective communication in programs and services or who wish to request special accommodations for examinations, please call (608) 266-2852 or TTY at (608) 267-2416.

**Complaints:** Procedures for alleging violations of the Americans with Disabilities Act of 1990 may be obtained by calling the Department's ADA Coordinator at (608) 266-8608 or TTY at (608) 267-2416.

# Wisconsin Department of Regulation & Licensing

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## DIVISION OF PROFESSIONAL CREDENTIAL PROCESSING

### WISCONSIN STATUTES AND ADMINISTRATIVE CODE ORDER FORM

For assistance with the open book exam (if required) or for your information, you may access the Wisconsin Statutes and Administrative Code on the department's web site at [www.drl.state.wi.us](http://www.drl.state.wi.us). If you do not have internet access, you may obtain this information through the public library.

If you would prefer to have a printed copy of any code book, you may purchase one directly from the department. Please submit this form along with a check in the amount of \$5.28 per book made payable to the Department of Regulation and Licensing (DRL) to the address listed above.

#### Mark which profession(s) you are requesting below:

- |  |   |
|--|---|
| <input type="checkbox"/> Acupuncture   | <input type="checkbox"/> Optometry Examining Board                          |
| <input type="checkbox"/> Athletic Trainers                                   | <input type="checkbox"/> Pharmacy Examining Board                           |
| <input type="checkbox"/> Chiropractic Examining Board                        | <input type="checkbox"/> Physical Therapists Affiliated Credentialing Board |
| <input type="checkbox"/> Dentistry Examining Board                           | <input type="checkbox"/> Psychology Examining Board                         |
| <input type="checkbox"/> Dietitians Affiliated Credentialing Board           | <input type="checkbox"/> Social Workers, Marriage and Family Therapists,    |
| <input type="checkbox"/> Hearing and Speech Examining Board                  | <input type="checkbox"/> Professional Counselors                            |
| <input type="checkbox"/> Medical Examining Board                             | <input type="checkbox"/> Veterinary Examining Board                         |
| <input type="checkbox"/> Board of Nursing                                    | <input type="checkbox"/> Podiatrist Affiliated Credentialing Board          |
| <input type="checkbox"/> Music Art & Dance                                   | <input type="checkbox"/> Massage Therapist & Body Workers                   |
| <input type="checkbox"/> Occupational Therapy/Occupational Therapy Assistant |   |

☐ # OF BOOKS REQUESTED x \$5.28 each = ☐ TOTAL AMOUNT ENCLOSED

Make your check payable to the Department of Regulation & Licensing (DRL) and return with this form to the address shown above.

NAME \_\_\_\_\_

COMPANY/ORGANIZATION \_\_\_\_\_

STREET ADDRESS/PO BOX \_\_\_\_\_

CITY/COUNTY \_\_\_\_\_

STATE \_\_\_\_\_

ZIP \_\_\_\_\_

**For Receipting Use Only**